2006

Ann V. Mark v. Intermountain Health Care Inc. : Reply Brief

Utah Court of Appeals

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IN THE UTAH COURT OF APPEALS

ANN V. MAAK,

Plaintiff/Appellant

v.

INTERMOUNTAIN HEALTH CARE INC., DBA LDS HOSPITAL,

Defendant/Appellee

v.

REGENCE BLUE CROSS BLUE SHIELD,

Third-Party Defendant

APPELLANT'S REPLY BRIEF

Case No. 20060124 – CA

Civil No. 030911869

Trial Court Judge: Timothy Hanson

(*Oral Argument and Published Disposition Requested*)

Appeal from Memorandum Decision and Order and Final Judgment in a Civil Case entered by the Third Judicial District Court in and for Salt Lake County,

Judge Timothy R. Hanson

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ARGUMENT

I. Maak Never Agreed to Be Overbilled By IHC

Defendant/Appellee IHC Health Services, Inc. ("IHC") argues that plaintiff/appellant Ann V. Maak ("Maak") agreed to the overbilling that forms the crux of her complaint, when such is simply not the case. The ruling below misconstrues basic contract principles when arriving at a determination that IHC's billing procedures were contractually allowable. The prima facie elements of a contract-based claim are: "(1) a contract, (2) performance by the party seeking recovery, (3) breach of the contract by the other party, and (4) damages." Campbell, Maack & Sessions v. Debry, 38 P.3d 984, 991 (Utah Ct. App. 2001). Maak's first and second claims for relief are based on a contract theory. IHC points to two agreements to support its argument that Maak consented to be overbilled: (1) the Consent and Conditions of Admission dated April 2, 2002 (the "Admissions Document") signed by Maak's husband upon admission for emergency treatment; and (2) the Health Care Agreement (the "Regence Plan Agreement") between Regence Blue Cross Blue Shield of Utah ("Regence") and Maak's husband (R. at 202-45). Neither of these agreements supports this overreaching proposition.

A. The Admissions Document

IHC urges a myopic reading of the Admissions Document when attempting to convince the Court that Maak agreed in advance to the overbilling that later occurred.

Paragraph g reads, in relevant part:

> **Financial responsibility**. Patient and the undersigned, if other than the Patient, each jointly and severally agree to ***pay for all the health care services rendered to Patient in the Facility*** including but not limited to any

> amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. . . .

(Emphasis added; R. at 194). IHC focuses only on the language that Maak should pay copayments, deductibles, and/or coinsurance "regardless of amount by paid by insurance or third party payor" to IHC. In doing so, IHC ignores the precursor language immediately above in the same paragraph that states that Maak agreed in advance to pay only "for all the health care services rendered to Patient in the facility including but not limited to any amounts not paid by any insurance company or other third party payor." Payment for "all the health care services rendered" thus is a cap to Maak's payment obligation, regardless of insurance plan sponsorship.

Moreover, the term "services rendered", and Maak's agreement to ensure that IHC be paid for "all" the same (and no more), is important and brings into play the statutory provisions of UCA § 26-21-20. That statute requires IHC to give an itemized statement of charges relative to "medical care or other services from that hospital." See UCA § 26-21-20(1). Such itemization was required to include "each of the charges actually provided by the hospital to the patient." UCA § 26-21-20(3). Thus, the statute is important to Maak's claims not because Maak believed the EOB submitted pursuant to the statute to be a bill for payment (she recognized it as the explanation of benefits) but because it demonstrates exactly the maximum amount of payment to which IHC was entitled for its "services rendered." That amount, as specified on the EOB, was $11,396.11. (R. at 16-19.) There is no inconsistency between this plaint-language

reading of UCA § 26-21-20 and other provisions of Utah's Insurance Code, as argued by IHC. (See IHC's Appellee's Brief at 23-25.)

When read as a whole, the Admissions Document, including the clause upon which IHC relies (stating a payment obligation "regardless of amount paid by insurance or third party payor"), provides only that IHC must receive at least $11,396.11 through some combination of insurance and patient payments. This interpretation is reasonable and reads all provisions of paragraph g and the Admissions Document together. *See, e.g.*, Jones v. Hinkle, 611 P.2d 733 (Utah 1980) ("It is axiomatic that a contract should be interpreted so as to harmonize all of its provisions.").[1] IHC's alternative explanation is not reasonable and does not harmonize all the terms of the entire Admissions Document. [See R. at 274, 284-86 (arguments from Maak's memorandum supporting motion for partial summary judgment); 457-58 (arguments from Maak's reply memorandum).] The moment IHC received payment, from any source, equal to $11,396.11, Maak had fulfilled her contract with IHC. See, e.g., Restatement, Second, Contracts § 235 ("Full performance of a duty under a contract discharges the duty."); Holmes Dev., LLC v.

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[1] Any doubt as to the proper interpretation of a contract is construed against the drafter. *See, e.g.*, Jones, Waldo, Holbrook & McDonough, 923 P.2d 1366, 1372 (Utah 1996) (noting the "general rule of contract interpretation that ambiguous language is to be construed against the drafter"). Further, contracts of adhesion of this sort that the health-care provider demands be signed as a precondition to treatment are narrowly construed in favor of the patient's interpretation. *See* Russ v. Woodside Homes, Inc., 905 P.2d 901, 906 (Utah Ct. App. 1995) ("A contract of adhesion is an agreement forced on one party by another who has superior bargaining strength. In other words, an adhesion contract is one in which the party has no alternative."); Broemmer v. Abortion Servs., 840 P.2d 1013, 1017 (Ariz. 1992) (invalidating arbitration agreement between patient and medical clinic on basis of such agreement constituting an adhesion contract) (cited in Sosa v. Paulos, 924 P.2d 357, 362 (Utah 1996)). *Cf.* United States Fidelity & Guaranty Co. v. Sandt, 854 P.2d 519, 522 (Utah 1993) ("[A]n insurance policy is a classic example of an adhesion contract.").

Cook, 48 P.3d 895, 903 (Utah 2002) (summary judgment was proper in favor of party who had fully performed in accordance with the express contractual terms). IHC's efforts to collect more money from Maak after receiving full payment for services rendered constitutes breach of its contract with Maak and/or breach of the implied covenant of good faith and fair dealing, and such breach has damaged Maak.

B. The Regence Plan Agreement

Just as Maak did not agree to be overbilled pursuant to the Admissions Document, she did not agree in advance to IHC's overbilling pursuant to the Regence Plan Agreement. Here again IHC isolates a select passage of the agreement out of context. Specifically, IHC focuses on language in Section B.2.b of the Regence Plan Agreement that states providers, like IHC, "have agreed to accept Regence BCBSU's payment in accordance with contractual payment schedules" which schedules "can be greater than or less than the facility's actual charges for Covered Services." This argument overlooks the very next sentence of the Regence Plan Agreement, which states: "The Member's obligation for payment to a Participating Provider is the Deductible and/or Copayment and the Coinsurance ***as applied to charges for Covered Services*** in excess of Deductible and/or Copayment" (emphasis added). In other words, Maak's payment obligation, if any, to IHC was tied to IHC's actual charges for the covered services (those services that qualify for treatment under the plan) and not contractual schedules. The actual charges are reflected by the EOB itemization provided pursuant to UCA § 26-21-20 (R. at 16-19), not the DRG agreements between IHC and Regence.

II. IHC, not Regence, Is the Correct Defendant

IHC's argument that it did nothing more than follow the mandates of Regence also is not well taken. As the above discussion makes clear, the Admissions Document and Regence Plan Agreement contemplate circumstances where the provider does not receive payment from the insurer in an amount that exceeds the provider's own market rates for those services (such rates shown on the itemization provided pursuant to UCA § 26-21-20; R. at 16-19). IHC has admitted that the DRG-based reimbursement agreements between it and Regence also contemplate as much. [See R. at 197 ("In the vast majority of cases, the DRG reimbursement method used by Regence results in a payment to the Participating Provider that is lower than the provider's itemized statement of services."] Accordingly, Maak's situation is alleged to be a unique one.

IHC has provided no evidence in the Record to support its claim that Regence, not IHC, mandated the collection efforts against Maak made by IHC in these unique circumstances and under the applicable agreements. To the contrary, the record makes clear that IHC representatives, not Regence representatives, were the ones pursuing collection avenues against Maak. [R. at 296-353 (affidavit of Maak's husband reciting the collections-based correspondence between IHC and the Maaks).] IHC, not Regence, did that. Moreover, there is nothing in the behind-the-scenes DRG agreement between IHC and Regence that forces IHC to pursue collection of coinsurance, copayment, and/or deductible amounts when it already has received amounts from Regence above the actual, market charges incurred by IHC (those charges on the itemization; R. at 16-19). [See generally, R. at 438 (copy of Regence Blue Cross Blue Shield of Utah Participating

Hospital Agreement (Traditional Plan) dated effective January 1, 1984 and filed under seal.[2]] Stated differently, IHC has not, and cannot, show evidence from the Record that it would be in breach of contract with Regence by failing to collect the amounts it sought to collect, and ultimately did forcibly collect, from Maak. Accordingly, its argument that "[e]very act of IHC that Maak complains of in her Amended Complaint was undertaken in compliance with the Regence Plan and at Regence's direction" rings hollow.[3] This is particularly egregious when IHC has recognized as part of its collection-based correspondence that it received "***more money than total charges***" before it ever sought additional payment from Maak. [R. at 306 (letter of Marsha Ferrin dated August 5, 2002) (emphasis added).]

III. Maak's Appeal Is not an Attack on DRG-Based Methodology

IHC mischaracterizes Maak's claims as an attack on the concept of DRG-based billing. Maak has no quarrel with Medicare or the application of DRG-based billing in that context. Similarly, she has no quarrel with Regence and IHC applying the methodology as between them. Whether Regence wants to pay more to IHC than the actual value of the services performed by IHC because of DRG-based methodology is a decision for Regence to make. Maak's complaint surfaced, and the contractual breach

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[2] Maak has not cited to express provisions of this document because it was filed under seal, Maak will be prepared to address specifics of such agreement at oral argument of this matter, as deemed helpful by the Court.

[3] Indeed, in footnote 15 of IHC's brief, IHC contradicts its own statement when it asserts that "IHC never argued that it was required to bill Maak for her coinsurance." If not required to do so, then IHC was willingly pursuing collection of further amounts from Maak knowing that it

began, however, when IHC, after application of the DRG-billing methodology, determined that it was entitled to additional payment from her when it already had been paid an amount that exceeded what Maak contractually agreed to pay upon admittance to LDS Hospital – the actual charges that were later itemized on the statutorily required itemization of charges. (R. at 16-19).

Moreover, none of the DRG cases cited by IHC stand for such a proposition. Springdale Mem. Hosp. Ass'n v. Bowen, 818 F.2d 1377 (8th Cir. 1987) involved a challenge by a hospital to a requirement that a Notice of Program Reimbursement must be filed before the hospital could appeal Medicare payment determinations. The statements about DRGs were made in passing in the background/introduction section of that case. Similar is Alvarado Comm. Hosp., et al. v. Shalala, 166 F.3d 950 (9th Cir. 1998) (Administrative Procedures Act claim to "outlier" Medicare payments); York Hosp. v. Maine Health Care Fin. Comm'n, 719 F. Supp. 1111 (D.C. Maine) (challenging a Maine statute that factored Medicare payments into calculations of a hospitals' anticipated gross revenues); Sisters of Charity Hosp. v. Riley, 231 A.D.2d 272 (N.Y. App. Div. 1997) (determining that patient had to pay for charges incurred by the hospital not covered by Medicare). Medicare does not apply to the instant facts, and IHC's attempts to justify its overcharge as akin to something Medicare has done for decades therefore is unavailing.

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already had been overpaid the amount of actual charges incurred and knowing that Regence did not require the additional payments.

Although masked in vast explanations of Medicare billing and a discourse on the interconnectivity of the insurance world, IHC seeks nothing more than extra money for services for which it was overpaid by Regence. In short, IHC cannot enlarge Maak's obligation to pay only for "health care services rendered" to her by lauding the virtues of DRG-based billing. No matter how virtuous that billing scheme is in the abstract, it cannot and does not supplant the contractual limits that exist on the amounts that IHC can seek to collect from Maak.[4]

IV. Maak Has Abandoned None of Her Claims

In a footnote of its brief, IHC inaccurately states that Maak has abandoned all of her claims save her first claim for relief in the Amended Complaint. Brown v. Glover, 16 P.3d 540 (Utah 2000), which is the only case applying Utah's rules of appellate procedure upon which IHC relies for this assertion, simply does not say this. Instead, Brown warns of raising issues for the first time in the reply. Maak has not done that. To the contrary, footnote one of Maak's Appellant's Brief references the cryptic and deceptive billing statement issued by IHC as being "at the core of Maak's final three claims asserted in her case. Each of these claims contains as a core element such deception, and the cryptic, inexplicable upward increase in the overall bill under an entry

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[4] In Sisters of Charity Hosp., the Court makes a statement that a hospital can retain an overpayment made by Medicare, which is the equivalent of saying here that IHC would be allowed to keep any overpayment made by Regence. See id. at 277. IHC in fact has retained such an overpayment in this case. The contractual problems came when it then sought to seek even more overpayment from Maak. Neither Sisters of Charity Hosp. nor any other case cited by IHC supports that action.

description of 'Regence Blue Cross' satisfies the elements of these claims." (Appellant's Brief at X & n.1.)

Moreover, these issues were fully briefed in the Record below. Specifically, Maak's Third through Sixth[5] Claims for Relief are: (1) Violation of the Utah Insurance Fraud Act, UCA §§ 31A-31-103 (third claim); (2) fraud/misrepresentation (fourth claim); (3) Deceptive Trade Practices, UCA § 13-11a-3 (fifth claim); and (4) punitive damages (sixth claim). Each claim shares an element of deception, dishonesty, or misrepresentation, and the means employed by IHC to collect extra money from Maak on a completed contract constitutes the deception and fraud of which she complains.

The viability of each of these claims is readily apparent by comparing the final Billing Statement dated May 31, 2003 (R. at 255) with the elaborate explanation and characterization of that billing in IHC's correspondence to Maak. (R. at 305, 311, 317, 322). The Billing Statement lists three columns with column headers of "date, " "description," and "amount." After listing the amount charged for actual health care services rendered (i.e. $11,396.11) under the heading of "Previous Balance," IHC lists four entries. Three of those entries state only "Regence Blue Cross pmt" and the fourth entry says simply "Regence Blue Cross." There is no mention of DRGs, the law of averages, or behind-the-scenes agreements between IHC and Blue Cross. All of that emerged only after Maak and her husband demanded an explanation for the deceptively incomprehensible billing statement.

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[5] IHC's footnote 1 incorrectly identifies the first claim for relief as the exclusive contract claim. The second claim for relief (breach of implied covenant of good faith and fair dealing) also is contract-based.

The billing statement represents an omission of much of the important information needed to understand it, and such failure of disclosure is deception (concealing the actual processes at work), an unlawful trade practice (same), and a fraudulent misrepresentation (failure to fully disclose how billing was occurring and the basis for IHC's attempts to collect more than the value of its services), which entitles Maak and the class she seeks to represent to affirmative relief. *See, e.g.*, UCA § 31A-31-103 (insurance fraud exists when a service provider (IHC) "knowingly submits or causes to be submitted a bill or request for payment containing charges or costs for an item or service that are substantially in excess of customary charges or costs for the item or services . . .", as IHC did by sending its Billing Statement); Price-Orem Inv. Co. v. Rollins, Brown & Gunnell, 713 P.2d 55, 59 (Utah 2001) ("a party injured by reasonable reliance upon a second party's [IHC] careless or negligent misrepresentation of a material fact [IHC's representation of the full amount that would need to be paid relative to Mrs. Maak's medical treatment] may recover damages resulting from that injury when the second party had a pecuniary interest in the transaction, was in a superior position to know the material facts, and should have reasonably foreseen that the injured party was likely to rely upon the fact"); Crookston v. Fire Ins. Exch., 817 P.2d 789, 800 (Utah 1991) (enumerating the nine elements of fraud); UCA § 13-11a-3(t) (deceptive trade practices violation occurs whenever any person in the course of conducting business engages in conduct that "creates a likelihood of confusion or of misunderstanding").

Maak seeks to address all of her claims for relief upon remand of the case to the trial court. This includes pursuit of her class-action claims, which were not ruled upon

directly as part of the Court's final decision and order (R. at 682-92). Since there never was any substantive treatment of that aspect of her case, Maak seeks on remand to have the opportunity to meet the burden of demonstrating class-action status of this case.

V. Maak's Rule 56(f) Arguments Are not Waived

IHC incorrectly asserts that Maak injects new issues relative to the Rule 56(f) argument. Here, IHC focuses only on a few of the arguments contained in Maak's memorandum supporting her Rule 56(f) motion. (R. at 259-61). That memorandum expressly states that some of the relevant discovery sought at that time related to facts delineated in the accompanying affidavit. (R. at 261). The affidavit submitted in support of Maak's Rule 56(f) motion then sought information concerning the frequency of DRG-based overpayments, information concerning how such bills were calculated, and additional information that never was provided because the motion was denied. [R. at 264-65 (¶ 5 of affidavit).] All Maak knows about DRG-based billing comes from IHC's own self-serving statements, untested against relevant supporting documentation and unchallenged in a deposition. Discovery of the sort Maak sought very likely may have revealed inconsistencies, discrepancies, and/or other information that would have assisted in Maak's prosecution of her case. Denial of that motion thus was premature.

CONCLUSION

For all the reasons set forth above, this Court should reverse the ruling below consistent with the arguments set forth above and contained in Maak's Appellant's Brief.

DATED this 5th day of January 2007.

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CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of January 2007, a true and correct copy of the foregoing **APPELLANT'S REPLY BRIEF** was sent to each of the following via U.S. first-class mail, postage prepaid:

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